California Department of Mental Health Community Stakeholder Summer

Final Summary Report

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for the
California Department of Mental Health

In collaboration with the California Institute for Mental Health

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Executive Summary

During the summer of 2011, the California Department of Mental Health conducted a series of community mental health stakeholder meetings to gather input from mental health stakeholders regarding changes to state level mental health functions resulting from recent legislative changes and the 2011-2012 Governor's Budget May Revision.

Over the course of the DMH Stakeholder Summer, the Department heard from hundreds of consumers, family members, private providers, county representatives, local and state level consumer groups, and county organizations. The feedback has been categorized into five overarching themes:

1. Concerns Regarding State Level Mental Health
2. Benefits and Challenges of Local Control
3. Importance of Cultural Competence Leadership and Reducing Disparities
4. Integrity of the Mental Health Services (MHSA) Act
5. Role of Mental Health Consumers and Their Families

The findings related to each of the categories are summarized below. The sections that follow provide a detailed description of the Community Mental Health Stakeholder process including process planning, design, outreach and participation rates, as well as the stakeholder themes supported by participant's quotes.

1. Concerns Regarding State Level Mental Health

- State level executive leadership for community mental health is essential.
- To ensure system integrity and accountability, a state oversight function for both fiscal and program delivery is important.
- Program evaluation and quality improvement are essential functions.
- Stakeholders hope that mental health will have equal "footing" with physical health and position the state for national healthcare reform.
- There are advantages to integrating mental health and alcohol and other drugs, as long as they do not become the "step children" in the public health system.

- There is support for a single state organization responsible for behavioral health.

- The integration of mental health and alcohol and drug programs presents an opportunity to focus on co-occurring disorders.

- It is essential to ensure that mental health expertise is not lost with the shifting of mental health functions away from DMH.

- Many stakeholders were concerned about the current low number of DMH staff due to the transfer of Medi-Cal staff/functions to DHCS.

- Many stakeholders expressed support for maintaining the Department of Mental Health.

2. Benefits and Challenges of Local Control

- Many stakeholders see a larger role for local Mental Health Boards and Commissions and an opportunity for more responsive planning.

- There is hope for relief from some of the current bureaucracy including streamlined reporting requirements and centralized audit activities.

- There is a desire for improved data access.

- Stakeholders see changes at the state level as an opportunity for new rules that remove barriers to services.

- Some stakeholders expressed concerns that local staff may not have the adequate financial experience and resources to effectively manage the complexities of MHSA programs.

- In general, stakeholders want to ensure there is local accountability.

- Many stakeholders expressed apprehension that a shift to local control will result in inequities and/or redirection of funds**.**

- Do not lose the benefits of “statewideness” including outcome reporting and sharing of best practices**.**

3. Importance of Cultural Competence Leadership and Reducing Disparities

- Cultural competence and reducing disparities are high priorities.
- Stakeholders want state leadership for cultural competence at the highest level in a state department**.**

4. Integrity of MHSA

- Do not undo the achievements of MHSA as a result of current realignment efforts.
- Continue to focus on wellness, recovery, and resilience.
- Continue to strive toward an integrated service experience for consumers and family members; avoid fragmentation at all costs.
- Do not lose focus on prevention and early intervention**.**

5. Role of Mental Health Consumers and Their Families

- Mental health stakeholders are concerned that their existing power will be lost in the realigned mental health system.
- Stakeholders also see the changes as an opportunity for new voices to be heard about ways to improve delivery of local mental health services.

Introduction and Background

The administration of community mental health programs in California is undergoing significant change. The 2011-12 State budget and associated trailer bills, Assembly Bills 102 and 106, authorized the transfer of all Medi-Cal functions to the California Department of Health Care Services (DHCS), realigned Medi-Cal Specialty Mental Health from the state to counties, and significantly changed the state's responsibility for administering the Mental Health Services Act (MHSA) (Assembly Bill 100). Additionally, the FY 2011-2012 Governor's Budget May Revision proposes eliminating the Departments of Mental Health (DMH) and Alcohol and Drug Programs (ADP). The proposed elimination of DMH and ADP is scheduled to occur in the 2012-13 fiscal year.

In addition to the proposed elimination of DMH, changes required by Assembly Bill 100 and other legislative actions:

- Eliminate state level review and approval of county plans and expenditures by DMH and the Mental Health Services Oversight and Accountability Commission (MHSOAC);
- Replace DMH with the "State" in the distribution of funds from the Mental Health Services fund and the development of regulations necessary to implement MHSA;
- Replace DMH with the MHSOAC as having a possible role in providing technical assistance to county Mental Health Plans;
- Reduce the amount available from revenues deposited in the Mental Health Services fund for State administration from up to 5% to 3.5%; and
- Reduce DMH staff positions from 114 to a total of 19 MHSA funded positions.

In light of these significant changes, during the summer of 2011, DMH convened a series of community mental health stakeholder meetings throughout the state. The meetings were designed to inform stakeholders about the changes to state level mental health administration and to listen to ideas, input, and concerns regarding DMH non-Medi-Cal activities and programs. This report describes the stakeholder process including meeting design and participation levels and summarizes the information gathered during the meetings. The report appendices include materials distributed at the stakeholder meetings, meeting notes, as well as formal feedback and recommendations provided to DMH by mental health stakeholder organizations.

Community Mental Health Stakeholder Process Overview

Process Goals and Purpose

Before embarking upon the stakeholder process, the California Health and Human Services Agency (CHHS) and DMH leadership, in partnership with ADP and DHCS established the following goals for the process:

- Create a fully-inclusive stakeholder participation process;
- Communicate clearly about current state DMH re-organization;
- Educate stakeholders about the role, responsibilities, and resources for the DMH;
- Support efficiency and effectiveness for the community mental health system; and
- Develop a summary report in time for Governor's Budget consideration.

The purpose of the Community Mental Health Stakeholder Meetings was to:

- Gather stakeholder input on future functions and program responsibilities;
- Determine appropriate organizational placement of functions; and
- Define community mental health roles/responsibilities.

Guiding Principles for Stakeholder Input

CHHS and DMH leaders established guiding principles that would inform the stakeholder process. The MHSA General Standards, listed below, have guided planning, decision-making, and the provision of mental health services since the passage of the Act. Department leadership recognize that these General Standards should continue to inform all activities associated with mental health services, including realignment of state mental health functions.

- Community collaboration
- Client and family-driven
- Cultural competence
- Wellness, recovery, and resilience focused
- Integrated services experience

CHHS and DMH leaders also developed specific guiding principles for stakeholder recommendations and asked that stakeholders consider these guiding principles when providing input as part of the Community Mental Health Stakeholder process. The guiding principles are:

- Improve access to culturally appropriate services;
- Improve quality of care;
- Improve state accountability and outcomes;
- Improve efficiency and effectiveness of community mental health system;
- Include realistic implementation strategies taking into consideration available resources; and
- Fulfill organizational/policy/legal/statutory responsibilities.

Stakeholder Process Planning, Design, and Outreach

To achieve its goal of creating an inclusive stakeholder process, DMH actively engaged numerous partners and stakeholder groups to plan, design, schedule, and market the Community Mental Health Stakeholder Process. The California Mental Health Directors Association (CMHDA), California Mental Health Planning Council (CMHPC), and the Mental Health Services Oversight and Accountability Commission (MHSOAC) were briefed about the schedule and scope of the Community Mental Health Stakeholder process in July 2011. Key participants in the design and planning of the stakeholder process included the California Institute for Mental Health (CIMH), United Advocates for Children and Families (UACF), National Alliance on Mental Illness (NAMI) - California, Racial and Ethnic Mental Health Disparities Coalition (REMHDCO)

The table below (Table 1) includes the organizations and entities that were consulted in the planning, process design, materials development, education, outreach, and communication activities.

Table 1 Organizations/Entities Involved in Planning

State Partners	County Partners	Community/Advocacy Partners
• California Department of Alcohol and Drug Programs (ADP) • California Department of Health Care Services (DHCS) • California Health and Human Services Agency (CHHS) • California Mental Health Planning Council (CMHPC)	• California Mental Health Directors Association (CMHDA) • California Association of Local Mental Health Boards and Commissions (CALMHBC) • Workforce Education and Training Regional Partnerships	• California Network of Mental Health Clients (CNMHC) • National Alliance on Mental Illness (NAMI) - California • Racial and Ethnic Mental Health Disparities Coalition (REMHDCO) • United Advocates for Children and Families (UACF)

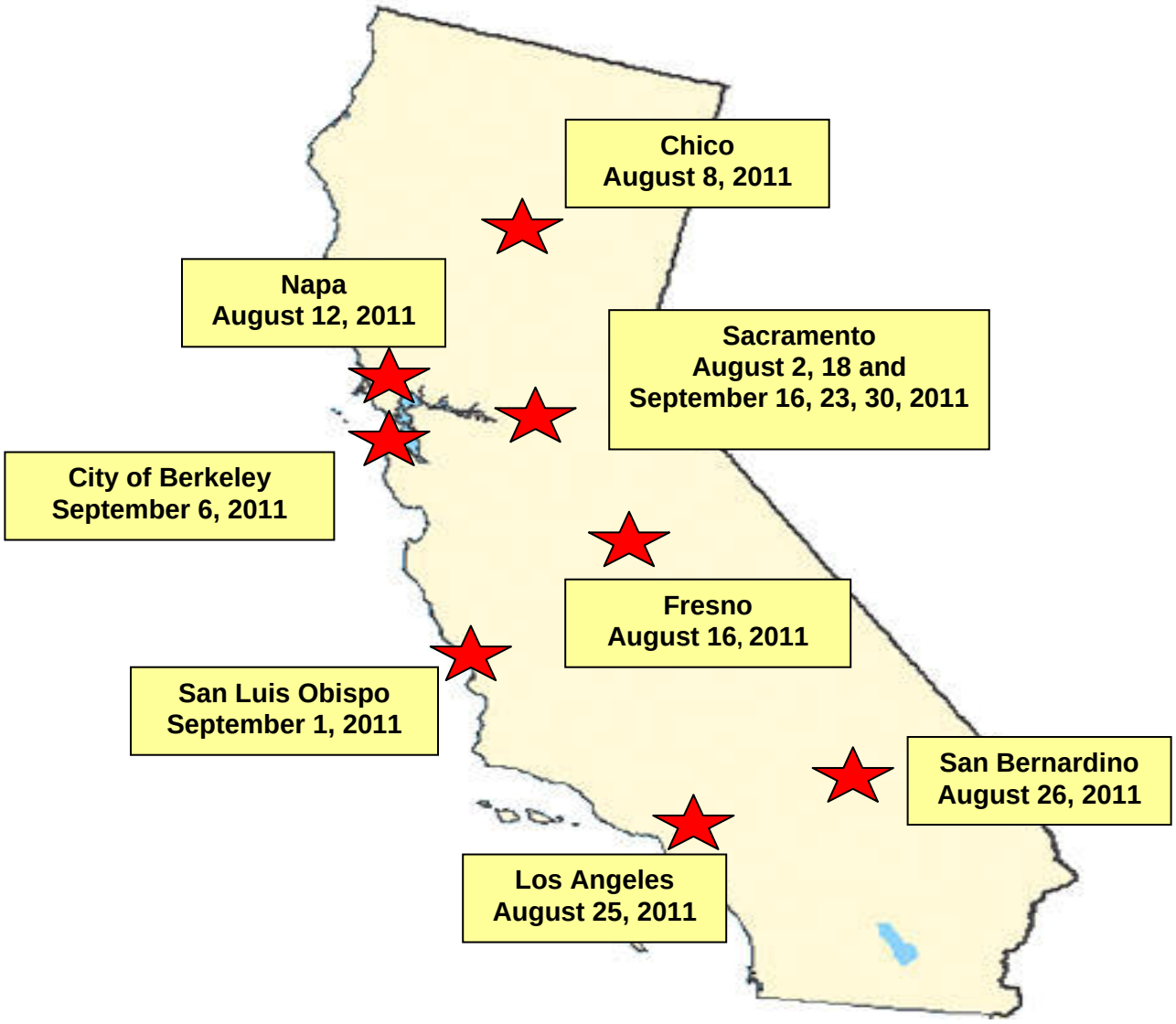
Meeting announcements were widely disseminated via DMH's vast distribution list, which includes a total of 323 individuals and organizations. Meeting participants were added to the distribution list using information provided on the sign-in sheets. DMH also encouraged partner organizations to invite local participants through their membership, contacts, and distribution lists. For each regional meeting, the Department worked with local partners including county and city Mental Health/Behavioral Health Department Directors and Cultural Competence / Ethnic Services Managers, private provider organizations, local mental health boards and commissions, as well as state level and local consumer organizations to:

- Schedule meetings at times that would result in high stakeholder turnout for meetings in their community;
- Seek referrals for interpreter services in threshold languages;
- Secure accessible, centrally located meeting facilities with telephone lines for remote participation; and
- Distribute meeting announcements and information to prepare for the stakeholder meetings.

Meeting Locations

Meetings were held in various locations throughout the state to ensure the greatest participation and diverse stakeholder input. The meeting approach included statewide meetings to be held in Sacramento and regional meetings. Locations for the regional (Northern, Southern and Coastal) meetings were carefully selected to ensure participation of large counties and their local stakeholders and small counties and their local stakeholders. A second Northern region meeting was added to the schedule to address the unique needs of the Greater Bay Area. Figure 1 on the next page highlights the locations of the stakeholder meetings.

Figure 1 Stakeholder Meeting Locations



In preparation for the regional stakeholder meetings, DMH hosted a Kick-off Stakeholder meeting in Sacramento on August 2, 2011. The purpose of the Kick-Off meeting was to present the proposed Community Mental Health Stakeholder process and meeting approach and to solicit feedback from participants. Stakeholders present at the meeting had considerable feedback about the meeting design, break-outs, stakeholder questions, and process. As a result, DMH refined the meeting approach for the regional stakeholder meetings.

In addition to the regional meetings held throughout the state, DMH arranged for two special sessions to present information about the Community Mental Health Stakeholder process and preliminary themes and findings. DMH sought focused input from both consumers and family members and county mental health directors, stakeholder groups of vital importance to California's public mental health system.

To that end, DMH partnered with DHCS to present the stakeholder process and to hear from participants at the 2011 NAMI California Conference on August 18, 2011. Representatives from NAMI CA were present at all of the regional stakeholder meetings; however, DMH's (and DHCS's) participation at the conference provided a unique opportunity for consumers and family members to voice their concerns and provide feedback regarding the future of mental health functions at the state level. NAMI California's formal recommendations are included in this report as Appendix XIV.

On September 7, 2011, DMH leadership met with the California Mental Health Directors Association (CMHDA) to obtain input from the CMHDA Governing Board. Representatives from the Mental Health Services Oversight and Accountability Commission (MHSOAC) and the California Mental Health Planning Council (CMHPC) were also invited to attend. As with all of the stakeholder meetings, this meeting was open to the public and a handful of consumers, family members, and advocacy organizations were present as well. CMHDA provided considerable input during this meeting. CMHDA's written recommendations about state mental health functions were developed and approved by all of California's county mental health directors. Formal recommendations from these organizations are included in Appendices X-XII. Input from these organizations is also reflected in the findings section.

Meeting Approach

Each regional meeting featured the following format:

Pre-Meeting Education Session – Each regional stakeholder meeting was immediately preceded by an education session designed to prepare attendees to participate in the stakeholder process. During the education sessions, DMH representatives provided background information about the legislative changes and state level mental health functions and responded to participant questions about the changes. In addition, participants were introduced to the stakeholder process and design, guiding principles, and the format and stakeholder questions for the stakeholder meeting that would follow. In addition, participants received information about how to contact the Department and where to direct additional feedback and questions about the process. Select meeting materials can be found in Appendix I of this report.

Community Mental Health Stakeholder Meetings – During the stakeholder meetings, a local mental health director and a representative from the DMH directorate welcomed participants. The agenda for the Stakeholder Meeting was similar to the Education Session agenda, with the addition of stakeholder reflections and small group breakout sessions. Breakouts were generally divided into three groups – Consumers/Family Members/Advocates, Providers, and County Representatives. At a handful of regional meetings, stakeholder groups were combined to balance out the small groups.

During the Stakeholder Meetings, participants were asked four sets of questions:

1. Based on today's presentation, what are the changes in mental health at the state level that stand out for you? (Large group)

2. Based on what you heard today, what opportunities do you see as a result of the transition at the state level? (Small groups)

3. Which entity should assume responsibility for the functions/programs listed?* What functions/programs are missing from the list? (Small groups)

   *For this question, facilitators walked participants through a handout that lists state mental health functions and state and local organizations. This handout can be found in Appendix I of this report.

4. What do you believe are the challenges associated with the changes to mental health at the state level? How can these challenges be addressed? (Large group)

Participant responses to all of these questions were captured on flipcharts by a recorder. At the conclusion of the small group breakouts, each group was asked to share with the large group the opportunities they identified (question #2).

Additional Vehicles for Stakeholder Input

DMH provided a variety of vehicles through which stakeholders could provide input including a Facebook page dedicated to the Community Mental Health Stakeholder Process. The Facebook page allowed stakeholders to provide feedback about the meetings as well as engage in interactive discussions with DMH staff via the discussion board option. DMH also utilized Twitter to keep "followers" apprised of upcoming stakeholder events. Furthermore, all meeting materials, including meeting announcements, PowerPoint presentations, and handouts were posted on the DMH website. Appendix XV includes screen shots of the DMH Facebook page, Twitter page, and DMH website.

Stakeholders were encouraged to provide input electronically and in person by:

- Sending additional comments and recommendations to DMH at CommunityMHStakeholder@dmh.ca.gov;
- Visiting the CA Community Mental Health Stakeholder Page on Facebook;
- Following CAMHStakeholder on Twitter; and
- Submitting comment cards to DMH representatives at a stakeholder meeting.

Comments received through these vehicles were reviewed and analyzed along with all other input gathered during the stakeholder process.

Constraints and Challenges

While the Community Mental Health Stakeholder process resulted in enthusiastic and diverse stakeholder participation, the process was limited by the following constraints:

Compressed timeline – One of the Department's goals for this process is to ensure that a summary of stakeholder input (i.e., this report) is provided to the public in time for the Governor's budget consideration later this year. This goal required that organizing, scheduling, design, planning, marketing, outreach, education, and convening of these regional meetings occur in a very compressed timeframe. As a consequence, announcements for some of the regional meetings were not disseminated in the desired lead time to achieve maximum stakeholder outreach and subsequent participation.

Qualitative results – DMH designed these stakeholder meetings as focused conversations to gather opinions, input, and recommendations. It is not possible to report the number of stakeholders that share a specific concern, opinion, or recommendation. Rather, the feedback is conveyed through narrative themes that emerged from the stakeholder meetings.

Stakeholders' limited knowledge of and familiarity with state mental health programs and functions – State mental health functions are myriad and complex. Many stakeholders at each regional meeting indicated that they do not have sufficient knowledge to make informed recommendations about state level functions. During the meetings, DMH representatives educated stakeholders about the functions; however, an in-depth education strategy was not an option due to time constraints.

Resources – The State and local mental health departments are undergoing tremendous organizational and system change and budgetary challenges. Devoting limited staff resources and time to these meetings required a tremendous amount of planning and dedication by the public sector.

Translation and Interpretation Services – The State DMH and local mental health departments demonstrated their commitment to ensuring language access by investing resources for translation of meeting announcements and interpreter services for all of the Community Mental Health Stakeholder Meetings. The availability of interpreters allowed for the participation of Limited English Proficient (LEP) and monolingual stakeholders from California's ethnically and linguistically diverse population. With the assistance of the county mental health departments' Ethnic Services Managers, DMH was able to provide interpreter services at each of the regional meetings in the county's threshold language as well as American Sign Language (Los Angeles and San Bernardino).

Stakeholder Process Outcomes

Throughout the Stakeholder Summer 2011, the State DMH conducted a total of twelve stakeholder events, including eight regional stakeholder meetings across the state over a six-week period, August 2, 2011 to September 7, 2011.

Stakeholder Meeting Participants by Location

Stakeholder meeting participants were asked to sign-in and identify themselves in one of four stakeholder groups: 1) Consumer/family member/advocate; 2) Provider; 3) County Representative; and, 4) Other[1]. Table 2 below shows the number of participants by stakeholder group at each meeting (based upon information provided on sign-in sheets).

Table 2 Community Mental Health Stakeholder Meeting Participation

Location and Date	Consumers/ Family Members/ Advocates	Providers	County Employees	Other	Phone Participants	Total
Sacramento Kick-off August 2, 2011	17	17	10	34	181	259
Butte County August 8, 2011	10	20	16	7	24	77
Napa County August 12, 2011	4	7	7	1	12	31
Fresno County August 16, 2011	40	12	11	17	31	111
NAMI CA Conference, Sacramento, August 18, 2011	85	9	3	1	N/A	98
Los Angeles County August 25, 2011	115	93	33	6	13	260
San Bernardino County August 26, 2011	31	30	30	0	1	92
San Luis Obispo County September 1, 2011	9	24	32	2	5	72
City of Berkeley September 6, 2011	2	5	8	5	3	23
CMHDA September 7, 2011	3	0	18	3	3	37
Total	316	217	168	76	273	1060

[1] The “Other” category includes legislative staff, college/university staff and/or students, and individuals who did not identify themselves.

Findings

The section that follows describes the findings from the stakeholder process. The input gathered during the process was compiled, analyzed, and organized into themes. The themes are supported by direct quotes from stakeholder comment cards or emails and/or flipchart notes from one or more of the Community Mental Health Stakeholder Meetings. The selected quotes are representative of stakeholder input. Many additional comments related to the themes were submitted to DMH. Notes from each meeting, including stakeholder comments captured on flipcharts, can be found in Appendices II- IX of this report.

The input gathered at the meetings was as varied as the consumers, family members, advocates, county representatives, and providers who participated in the process. The themes presented below are perspectives that were heard consistently. In some cases the themes contradict each other – a reflection of the diverse and divergent voices of individuals with an interest in the mental health system. Notably, no consistent themes emerged across like groups. For instance, while some consumers/family members advocated for local control; other consumers/family members expressed anxiety that counties would not be held accountable for providing quality services.

In general, stakeholders did not reach consensus about which entity should be responsible for state level mental health functions. While many stakeholders believed that some of the functions should remain at the state level, references to "the State" in stakeholder comments typically do not denote a preference for a particular state organization, including the Department of Mental Health.

The themes are organized into five overarching themes:

1. Concerns Regarding State Level Mental Health
2. Benefits and Challenges of Local Control
3. Importance of Cultural Competence Leadership and Reducing Disparities
4. Integrity of the Mental Health Services (MHSA) Act
5. Role of Mental Health Consumers and Their Families

1. Concerns Regarding State Level Mental Health

While it is difficult to quantify stakeholder perception regarding the placement of state level mental health functions, clear themes about priorities emerged during the stakeholder meetings. Themes associated with placement of mental health functions are described below.

According to community mental health stakeholders, state level executive leadership for community mental health is essential.

"Where is the executive leadership in the current DMH organization chart?"

"The mental health leadership needs to have subject matter expertise."

"Administrative leadership needs dedicated positions with individuals with content expertise in decision-making. Mental Health executive role decision-makers should remain, so there is structure, stability, and mental health administration."

For many stakeholders, oversight (e.g., plan review, auditing, ensuring county compliance, etc.) is the most important state mental health function. While there was no consensus across stakeholder groups about which state entity should be responsible for oversight, stakeholders believe that there is a clear role for the state in ensuring that counties are held accountable for MHSA provisions.

"The State needs to provide a leadership and oversight role. There should be some strong commitment to leadership and oversight and standardization. Some counties do not roll out services in a consistent manner."

"There is a need to expand oversight and have an entity to assume this function."

"[I am] concerned about quality of services with no state level oversight. Our county is the gold standard, but what about other counties that don't have enough staff?"

"If the money goes to the locals, who is going to have oversight of the counties (besides the Board of Supervisors)?"

***"**The MHSA was supposed to be transformative, voluntary services. With a lack of state level oversight, who will ensure that services will be voluntary?"*

Effective financial oversight is also a high priority for mental health stakeholders. However, there was no consensus as to who should be responsible for this function.

"We need local authority for financial oversight. However, there is a risk of abuse if there is a lack of oversight."

"The state should retain responsibility of financial oversight."

"CalMHSA should have financial oversight."

While stakeholders believe that program evaluation and quality improvement are essential functions, there was no consensus regarding where those functions belong (state vs. local level).

"When it comes to data and quality improvement, it can be difficult to do that locally because we are too close to the action or we don't see the flaws or cover-ups."

"It should be a collaborative process that includes state and local systems."

"We want support from the state but we also want local control of quality improvement and program evaluation."

"The state can provide education and technical assistance."

Time and again, stakeholders expressed their hope that this change will give mental health equal "footing" with physical health and position the state for national healthcare reform.

"The most exiting opportunity is the potential for mental health services to be integrated with public health approaches and practices."

"Organizing around funding source fragments and creates silos. We need to think 5-10-15 years. Healthcare reform. I would like to see a Department of Health Systems w/ DHCS, ADP, DMH "not merging" but coming together as systems.

"…Given the major shifts in our nation's health care policies, we believe an integrated focus on mental health, substance abuse, and physical health is more feasible if the various government healthcare programs are administered by one state entity."

While many stakeholders see advantages to integrating mental health and alcohol and other drugs, they are fearful that mental health and substance use disorders will become the "step children" in the public health system.

"Within community health clinics, there is a concern about physical healthcare trumping everything. Is there a way to stage it so that specialty mental health services don't get lost?"

"The integration of mental health, substance abuse, and physical health presents the danger of loss of identity as well as financial dependence for mental health which may eventually hurt the mental health budget because, historically, physical health always gets the priority. We need to be extremely vigilant to avoid that kind of uncertain future for mental health."

"Putting Mental Health and substance abuse under DHCS is ok if: 1) they combine mental health and substance abuse and create a HIGH LEVEL leader and function within Health Care Services. 2) Initial funding for both services is same (or higher) and it increase over time, commensurate with need."

"I agree with the danger of fragmentation. We need unifying principles. If DMH and ADP are folded into DHCS, they should change their name to be more inclusive and unifying."

Some stakeholders expressed support for a single state organization responsible for behavioral health.

"To maintain "statewideness" there should be a single Behavioral Health entity."

"Maintain or make a separate bureau/dept. for Behavioral Health to preserve the voice of Mental Health and to assure direct communication with the Director of DHCS."

Many see the integration of mental health and alcohol and drug programs as essential to preventing consumers with co-occurring disorders from "slipping through the cracks."

"When Alcohol and Drug and mental health are joined, there are greater co-occurring services at local level. If the state combines, the state might be better coordinated between both sides, make it easier to treat both at same time."

"[Create] new programs addressing dual problems where resources can be used across both conditions."

"I feel that 70% of consumers have alcohol and drug issues, then they should be connected more (co-occurring disorders). "

"This is a good opportunity to meld co-occurring disorders together, keep things from slipping through the cracks."

"Having DHCS administer both mental health and substance use programs will provide an integrated focus on mental health, substance use, and physical health. Given the broad overlap among populations of individuals in need of mental health care, substance abuse disorder treatment, and primary health care, we think it makes sense that the variety of government programs in these arenas be administered by one state agency."

Stakeholders want to ensure that mental health expertise is not lost with the shifting of mental health functions away from DMH.

"If we shift functions to different departments, there won't be sufficient training for new departments [so they] can do the work."

"With Medi-Cal mental health functions transferring to DHCS, will there be staff with the mental health background and knowledge to perform these functions?"

"We need to educate DHCS on mental health and substance abuse wellness and recovery principles so they become true equal partners as we head towards health care reform. "

Many stakeholders were dismayed by the current number of DMH staff and expressed concern that the Department has "an impossible job" with the current number of resources.

"There are a tremendous number of functions now at DMH – I'm concerned something will fall through the cracks."

"It's not possible to answer the question of what to do with 19 staff and where to put the remaining functions. It's an impossible situation."

Many stakeholders advocated for keeping the Department of Mental Health in tact.

"…we want to protect the identity of the California Department of Mental Health. Don't disperse the functions that remain."

"Reorganizing CA Healthcare Department, how much money does CA State save? I think keeping DMH as it is now is much better because DMH has good insight about Mental Health and substance abuse. Transforming Medi-Cal of DMH and Substance Abuse to [DHCS] might damage the good services [provided] to needy people."

"Giving functions to DHCS is risky. The Department of Mental Health has acknowledged and supported the Recovery Model described in the Mental Health Service Act. Advocacy groups were encouraged and heard. Without a department at the state level, I am very concerned that the process of transforming mental health services to ones that are truly client-driven and family-focused will be lost."

2. Benefits and Challenges of Local Control

Stakeholders embraced the potential benefits of local control including a larger role for local Mental Health Boards and Commissions and more responsive planning.

"…*Because of the composition of all the county mental health boards and commissions, statewide, our respective commissions offer another avenue to involve consumers in this process and to provide a voice to concerned members of the public. I hope our government is receptive to listening to the concerns and recommendations of mental health consumers and advocates. "*

"More local control with focus – hopefully with local Mental Health Boards and Commissions."

"This can create a more organic process – an opportunity to really hear from county boards."

"Hopefully this will result in bottom-up planning that is more responsive. Counties are the experts."

"Tighter link between community needs and county response may lead to more customized/ pilot programs/creative intervention programs/innovative programs."

"Helps for services to be at the county level because we are closer to the people receiving services. We know our demographic and can tailor services."

Stakeholders also hope that current realignment efforts will alleviate bureaucracy.

"To facilitate improvement of mental health services, make documentation/paperwork more uniform, easier to understand, a 'boilerplate' to provide services. Design a standardized process from county to county."

"Streamline extra bureaucratic layers that use up funds."

"Reduce paperwork/eliminate duplication, pay providers quicker."

"Reducing counties' required administrative activities would help counties maximize available resources to provide direct consumer services."

In addition, stakeholders are hopeful that reporting requirements and audit activities can be streamlined and centralized.

"We should have one centralized location to report data so counties do less work and spend less time on reporting."

"Reduce the duplicated requirements due to different funding streams with different funding requirements."

"Bringing enforcement/documentation in-house is a good opportunity. We are spending time trying to anticipate auditors (gathering documentation, treatment plans). It would be wiser to spend time seeing clients and not worry about documentation standards."

"Unless the CSI [Client Services Information] system will change, it makes sense to have counties report this data to one entity with a unified data set and one way of reporting."

Stakeholders expressed a desire for improved data access.

"Wherever this information lives (data) there has to be a uniform/shared system so that everyone (all State entities) can have access to this information merged reporting system."

"It is important to create opportunities for counties to extract and utilize data."

"Make data more accessible. ADP does a great breakdown for every county. They do the work for me."

Stakeholders see changes at the state level as an opportunity for new rules that remove barriers to services.

"Current rules and regulations surrounding MHSA funds are too strict and prohibitive. Many people are not able to access all the services they need because of these rules. This is an opportunity to remove many of these barriers and be able to provide services that are tailored to certain populations."

"Currently, there is a disparity between the way in which Medi-Cal services and community mental health services are provided and funded. This is an opportunity to balance out this disparity."

At the same time, stakeholders expressed concern that local control comes with risks and challenges including local inexperience with MHSA:

"It makes sense to realign to the local level only if locals know what they are doing - rural counties do not have as much history with MHSA; knowledgeable staff is retiring/leaving; there is a reluctance to hire consumers."

"There are unique challenges for small counties."

"There is an assumption that counties have the expertise that is 95% true, but that is not necessarily true about housing. It's a whole different field, level of expertise, etc. County mental health/behavioral health providers are not housing experts. Serious thought needs to be given to this if these responsibilities are shifted to the local level."

The most commonly voiced concern associated with local control related to local accountability.

"[We need] protections so that counties don't redirect funds if they don't think mental health is important."

"Local control is disempowering for people. Where is the accountability? We need to create an enforcement system."

"It is critical for the state is to provide accountability for program evaluation – there must be documentation that programs are getting the outcomes that are significant."

"While program administration and delivery of services are the responsibility of counties, it remains the responsibility of the state to ensure the counties administer the programs and delivery of services in accordance with applicable state and federal law."

Many stakeholders expressed apprehension that a shift to local control will result in inequities.

"Shifting responsibilities is both an opportunity and risk – local fairness is an issue."

"What about small cities (or counties)? Will there be a difference between those that have more resources and those that have less resources? How do we balance that issue? My nephew had to come to a larger county to get more services. Counties need sufficient resources for our families and consumers."

Some stakeholders expressed concern that more local control result in decreased "statewideness."

"How can we measure the impact of programs and services on a statewide basis? How will we be able to share best practices statewide?"

"We could put federal funding at risk if we don't have a statewide standard measurement system. There has to be consistency of care."

3. Importance of Cultural Competence Leadership and Reducing Disparities

Stakeholders see a continued focus on cultural competence and reducing disparities as a high priority and an essential element of the mental health system.

"…Must prioritize prevention efforts in addressing disparities…On a local level they can create cultural centers as one stop meeting points and wellness centers incorporating non-traditional partners. Disparities affecting African Americans are appalling throughout the state."

"We need to support Asian American/Pacific Islanders consumer/peers as advocates and community mental health workers by funding culturally competent training, advocacy and wellness peer programs that are facilitated by API peers because of stigma culture, we lack API peer services."

"I would like to request that the Office of Multicultural Services remain in tact. We need this office to make sure we have programs like Native American Health Center that can provide specialized care for a population that is underserved and not served appropriately by the county."

"[The state should] demonstrate commitment to ethnic diversity and cultural inclusion of older adults, deaf and hard of hearing and legally blind."

"If the Office of Multicultural Services is not preserved, the quality of California's commitment to culturally competent mental health services and reducing mental health disparities would be in jeopardy. That office is in charge of many important projects including the California Reducing Disparities Project and oversight of the Cultural Competence Plan Requirements report."

Stakeholders want to state leadership for cultural competence at the highest levels.

"There should be continued focus on the office of multicultural services given the vast disparities in underserved and under represented communities. To guarantee this focus, the Office of Multicultural services should be high up in any organizational chart."

"It is vital that the Office of Multicultural Services (OMS) remain in tact, including retaining the Chief's position that reports directly to a department or agency director. Cultural competence and reducing disparities need to be given the high priority that is required to achieve the progress in mental health services in California."

"…Adequate, high-level leadership within DHCS would be charged with promoting mental health, wellness, resiliency and recovery in California's diverse communities."

4. Integrity of MHSA

Stakeholders recognize the tremendous progress that has resulted from the MHSA, and, overwhelmingly, do not want to "go backward" as a result of realignment.

"Fear of "step back" to medical model instead of recovery model."

"[We need to] maintain institutional memory of how things happen (i.e., DMH and system in general), this is not the first time that there has been major change. What will happen to people in poor communities? There is some ongoing memory of what is happening right now, some continuity of history."

"Changes are great and often necessary however fragmenting our services will not improve the quality services instead it might create more chaos and separation. Instead, if we have to "transfer" services to Public Health for

instance, why not join them, or have them join our services and review together what we had done, so far, what had not worked and how to move forward in a partnership fashion. MHSA has been the best thing that has happened in the last few years. Why reinvent something that is working well?"

"Keeping alive the core of the things we learned through MHSA will help us through this transition."

Stakeholders indicated that any changes in the mental health system must continue to reflect the MHSA general standards:

Continue to focus on wellness, recovery, and resilience.

"Expand the concept of wellness and recovery across the system of care. Wellness and recovery can become the baseline for all services."

"Client/Recovery movement cannot lose its momentum. Wellness and recovery's higher standard should be the minimum, raise the standards across the board."

Continue to strive toward an integrated service experience for consumers and family members, avoid fragmentation at all costs.

"Fragmentation of responsibilities leaves the consumer with more difficulties in navigating the system of care but will also increase cost."

"We do not support the fragmentation of authority which would likely cause difficulty for providers in accessing funding, which could disrupt services. If system changes must take place, individuals with expertise in mental health should be in place at other departments now in charge and DMH should remain as a pass-through or as a guidance resource for these other department."

"The transfer of the Medi-Cal functions for mental health makes good sense and will increase efficiency. However, to further fragment the mental health functions that were delivered by State DMH between the MHSOAC and other agencies is a mistake. There must be a strong centralized organization for all other mental health functions but MOST of ALL there must be LEADERSHIP in Sacramento related to development."

"It is better to have one system of care. Having the functions/funding broken up could cause more problems (e.g. reporting to multiple entities)."

"The mere co-location of DMH subsumed within DHCS does not guarantee true integration of care."

Stakeholders want to ensure that the focus on prevention and early intervention is not lost as a result of the state mental health changes.

"Prevention and Early Intervention funding is a state level funding source – we should not lose PEI focus."

"While it is important for counties to have local control on how services are prioritized and delivered, it is equally important to have statewideness in mental health policy. Mental health policy in California has not been proactive in the past but, with the advent of parity and health care reform, there is an opportunity for development of mental health policy that includes more prevention and early intervention. It is clear that good mental health services/treatment initially can prevent expensive hospitalization and incarceration and great human costs. Development of prevention and early intervention services statewide makes good economic sense and would be good public policy."

5. Role of Mental Health Consumers and their Families

Mental health stakeholders are concerned that their voices will be lost in the realigned mental health system.

"Who will speak for community in the new reality?"

"I think there needs to be a louder consumer/voice in this whole DMH to DHCS transition process and would be willing to work on that level. I am from a smaller county (Butte) and am very concerned that the "little person" is being over looked."

"As a youth with a family with mental health, how can I, or other youth become more involved and aware of what's being changed, how can we have a say and have our voice inputted when there isn't a voice for us (or representation). Are their trainings or workshops out there for the youth?"

"This is an excellent opportunity to include "meaningful" recommendations from all of California's citizens. The greatest challenge is to not maintain the "status quo." Simply because the belief is that there is no money to meet the MHSA expectations as governed by the law and what the citizens of the Great State of California express what they need in order to experience good mental health."

"How do we keep the consumer voice at the state level?"

"Will state legislators still listen to local stakeholder input without support of state DMH?"

"[I am] concerned, in this transition, that we might lose a statewide voice and advocacy in Administration. Maintain a strong statewide voice in light of healthcare reform to work with the Feds to keep mental health in the discussion and prevent our folks from becoming more invisible."

"WE MUST BE AT THE FINAL DECISION MEETINGS –Nothing About Us Without US. That Means ALL of us."

At the same time, stakeholders see the changes as an opportunity for new voices to be heard. The changes at the state level provide opportunities for:

"…others to come to the table to provide input."

"…youth engagement."

"…more partnerships with Aging groups and regional centers."

Summary

The findings from the Community Mental Health Stakeholder Process reflect the diversity of California. While some stakeholders are ready to embrace the impending changes; others are anxious and uncertain about what these changes will bring. It is clear; however, that California's mental health stakeholders were appreciative of the opportunity to provide input into the current realignment efforts and transition of functions. Stakeholders are also eager to continue their participation in the process and want to stay informed of all decisions made about the future of mental health at the state level.

The five overarching themes described in this report reflect the areas of most concern to the stakeholders. At each regional meeting, the stakeholders expressed their ideas about oversight, local control, cultural competence, the role of mental health at the state level and the need for continued mental health leadership, and, most commonly, the continued role of consumers, family members, and community members in the decision-making process. While many stakeholders found it challenging to provide specific recommendations about the placement of mental health functions, most stakeholders expressed the need for inclusion, efficiency, streamlined data reporting processes, mental health

leadership, improved access to and navigation of comprehensive services, and the ability to plan for the future with health care reform in anticipation of an integrated service system.

The DMH Community Stakeholder Process was successful despite the constraints and challenges (compressed timeframe, lack of qualitative results, etc.), because the stakeholders are deeply and personally invested in ensuring the continued funding/resource allocation, parity, accessibility, and quality of services in California's public mental health system.

Next Steps

A draft of this report was released for public review on September 16, 2011 following a statewide webinar to review the findings from the Community Mental Health Stakeholder Summer. DMH hosted two webinars to provide stakeholders with an opportunity to provide feedback to the report. All feedback received on the draft report, as well as any additional input into the state level mental health functions, is reflected in this final report.

The final report may be used for consideration regarding the Governor's policy, program, and budget decisions for 2012/2013. DMH's commitment to engage stakeholders will continue through monthly meetings during October 2011-June 2012. These monthly meetings will afford stakeholders the opportunity to provide on-going feedback as the state level transition unfolds. DMH will also continue to post new information, as it becomes available, on the DMH website; as well as monitor and post on Facebook and Twitter. Stakeholders are encouraged to continue participation in this ongoing Community Mental Health Stakeholder Process.

Stakeholders may continue to provide input through the following vehicles:

DMH Website
Please visit the Medi-Cal Transfer, Stakeholder Summer 2011 and Realignment Information webpage:

www.dmh.ca.gov

Click on **"Information Regarding the DHCS/DMH Medi-Cal Transfer, Summer Stakeholder, and Realignment"** under the "What's New?" section for meeting notices, information, and updates.

Facebook

Visit the **CA Community Mental Health Stakeholder** page on Facebook
http://www.facebook.com/pages/CA-Community-Mental-Health-Stakeholder/179811872085830

Twitter

Follow **CAMHStakeholder** on Twitter

Additional Comments?

Send written comments to:
CommunityMHStakeholder@dmh.ca.gov

**If you would like your comments to be posted on the DMH website, please indicate your permission in your email message.

Appendices[2]

I. Community Mental Health Stakeholder Meeting Handouts
II. Notes from Sacramento Kick-Off Stakeholder Meeting August 2, 2011
III. Notes from Butte Regional Meeting August 8, 2011
IV. Notes from Napa Regional Meeting August 12, 2011
V. Notes from Fresno Regional Meeting August 16, 2011
VI. Notes from NAMI CA Conference Stakeholder Meeting August 18, 2011
VII. Notes from Los Angeles Stakeholder Meeting August 25, 2011
VIII. Notes from San Bernardino Stakeholder Meeting August 26, 2011
IX. Notes from San Luis Obispo Stakeholder Meeting September 1, 2011
X. Notes from City of Berkeley Stakeholder Meeting September 6, 2011
XI. Stakeholder Comments Submitted Online (CommunityMHStakeholder@dmh.ca.gov)
XII. AB100 Workgroup Report
XIII. California Mental Health Directors Association Recommendations
XIV. Principles to Achieve Oversight and Accountability in a Changing Mental Health Services Environment- Mental Health Services Oversight and Accountability Commission
XV. MHSOAC's Role in a Changing Mental Health Services Environment
XVI. CA Mental Health Planning Council's Letter to Secretary Dooley
XVII. Mental Health Association in California Comments on DMH Reorganization
XVIII. National Alliance on Mental Illness, California Position Paper
XIX. United Advocates for Children and Families Comments on DMH Reorganization
XX. Rose King Comments on Community Services and Supports
XXI. MHSA Partners Forum Comments
XXII. Racial and Ethnic Mental Health Disparities Coalition (REMHDCO) Comments on DMH Reorganization
XXIII. California Emergency Management Agency (CalEMA) Comments on Reorganization
XXIV. California Coalition for Mental Health Report
XXV. Considerations for Reorganization Report on California's Departments of Mental Health and Alcohol and Drug Programs by Stella Lee and Richard Rawson
XXVI. Association of CA Caregiver Resource Centers Stakeholder Statement
XXVII. DMH Website, Facebook and Twitter Pages
XXVIII. DMH Acknowledgements
XXIX. List of Participating Organizations

[2] Appendices Posted on DMH Website:
http://www.dmh.ca.gov/Services_and_Programs/Medi_Cal/Medi_Cal_Transfer.asp